Part D Formulary Denial Intake

Client:

Name _____
Address _____
_____
Phone Number _____
SSN _____
Medicare Number (if different) _____
Medicaid Number _____

Authorized Representative (if any):

Name _____
Address _____
_____
Phone Number _____

Prescribing Physician:

Name _____
Address _____
Phone Number _____

Prescribed Medications:

Name	Generic/Brand	Dosage	Route of Administration	Tier
1.				
2.				
3.				
4.				

Continue on separate sheet as needed.

Part D plan:

Name: _____
Address: _____
Contact person: _____
Phone Number: _____
URL of plan formulary: _____
Applicable utilization management tools: _____
_____

Formulary Denial HIPAA Authorization
Signed_____ Date _____

Brief Case Summary

_____
_____
_____
_____
_____

Appeals Process:

- **Coverage Determination** **Date Requested: _____**

  Request to expedite? Yes / No Physician Statement prepared? Yes / No

  Date Sent: _____ Date Received: _____

  Date Coverage Determination Received: _____

- **Formulary Exception** **Date Requested: _____**

  Request to expedite? Yes / No Physician Statement prepared? Yes / No

  Date Sent: _____ Date Received: _____

  Appeal: _____

- **Redetermination** **Date Requested: _____**

  Request to expedite? Yes / No Physician Statement prepared? Yes / No

  Date Sent: _____ Date Received: _____

  Date Redetermination Received: _____

- **Reconsideration** **Date Requested: _____**

  Request to expedite? Yes / No Physician Statement prepared? Yes / No

  Date Sent: _____ Date Received: _____

  Date Reconsideration Received: _____

- **ALJ Hearing** **Date Requested: _____**

  Date of Hearing: _____ Jurisdictional Amount? $_____

  Video Conference or In-person Hearing: _____

  Date Brief of Law and Facts prepared: _____

  Date Submitted (remember to request a return receipt): _____

  Date ALJ Decision Received: _____

- **MAC Appeal** **Date Requested: _____**

  Date Brief of Law and Facts prepared: _____

  Date Submitted (remember to request a return receipt): _____

Referrals

From SHIP to Legal Services for the Elderly

Date _____
Contact _____
Reason for Referral_____
_____
_____

From Legal Services for the Elderly to SHIP

Date _____
Contact _____
Reason for Referral _____
_____
_____